OUTPATIENT HOSPITAL STATE PLAN
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Methods and Standards for Determining Outpatient Hospital Payment Rates
With Amendments Effective July 1, 1996

1000 STATUTORY BASIS

The outpatient reimbursement shall comply with all current and future applicable Federal and State laws and regulations and shall reflect all adjustments allowed under said laws and regulations. Federal regulations (42 CFR §447.321) require the Medicaid agency not pay more for outpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

2000 GENERAL PRINCIPLES

Outpatient hospital services will be paid at an interim rate per visit with a retrospective final settlement for each hospital's fiscal year based on the audited cost report for the hospital's fiscal year.

2100 Interim Rate. The interim rate for each hospital will be the sum of the rate per outpatient visit and the rural hospital adjustment per visit as determined under §4200 and §4300 respectively. For interim payment purposes, clinical diagnostic laboratory tests will be paid on the lower of charges or the Medicaid laboratory fee schedule. All other outpatient services will be paid at the interim rate less the payment for clinical diagnostic laboratory tests. Interim payments shall be subject to a retrospective final settlement.

2200 Final Settlement. The retrospective final settlement will be the hospital's allowable outpatient cost limited by the hospital's customary charges and rate per outpatient visit. In addition, the reimbursement for clinical diagnostic laboratory services will be limited to the laboratory fee schedule of the Wisconsin Medical Assistance Program or the hospital's charges for the laboratory services. Section 4100 describes final settlements in more detail.

2400 Hospital Licensure of Provider Premise. Only medically necessary covered services provided within the physical licensed premises of a licensed *hospital facility* are eligible for reimbursement under this outpatient hospital payment formula. Medically necessary covered services provided (a) in a facility which is not a licensed hospital facility or (b) in an unlicensed portion of a hospital facility are not eligible for reimbursement under this outpatient payment formula.

2600 Cost Report. Each hospital participating in the Wisconsin Medical Assistance Program (WMAP) shall prepare a retrospective Title XIX cost report at the close of its fiscal year. In-state hospital providers must submit the cost report and accompanying supplemental schedules to the Department's audit intermediary by the date required by Medicare for submission of the cost report. If a provider is granted an extension for Medicare, the WMAP will automatically extend its deadline. The report shall be accompanied by a certified financial statement and contain other information that may be required by the Department.

3000 DEFINITIONS

Hospital Facility. A *hospital facility* is the physical entity, surveyed and licensed by the Wisconsin Department of Health and ~~Social Services~~ Family Services under Chapter 150, Wis. Stats.. For hospitals not located in Wisconsin, a hospital facility is the physical entity that is covered by surveying, licensure, certification, accreditation or such comparable regulatory activities of the state in which the hospital is located.

Outpatient Base Year. The first hospital fiscal year beginning on or after January 1, 1987.

Final Settlement Year. The hospital fiscal year for which a retrospective final settlement is calculated.

Allowable Costs. The hospital's allowable Medical Assistance (MA) costs permitted by applicable Medicare standards and principles of reimbursement (42 CFR Part 405 and HIM-15).

Outpatient Visit. An admission to the outpatient hospital on a given calendar day, regardless of the number of procedures or examinations performed or departments visited. A maximum of one outpatient visit per patient per calendar day shall be recognized and paid.

Rate Per Outpatient Visit. The hospital-specific rate per outpatient visit determined from the outpatient base year and which serves as a maximum on payment for services provided in the final settlement year.

Clinical Diagnostic Laboratory Reimbursement. The lower of laboratory fee schedule amounts of the Wisconsin Medical Assistance Program or the hospital's laboratory charges for services rendered.

4000 METHODOLOGY FOR COMPUTING OUTPATIENT FINAL SETTLEMENT

4100 Limits on Cost Settlement.

Final settlement of outpatient reimbursement for a settlement year shall be a hospital's allowable audited outpatient costs in the final settlement year as determined according to applicable Medicare and Medicaid standards and principles of reimbursement. The resulting amount will be limited by the lesser of the following amounts:

1. Customary outpatient charges in the final settlement year,
2. The sum of (a) the *rates per outpatient visit* effective for the final settlement year multiplied by the number of Medical Assistance outpatient visits for the period plus (b) the *rural hospital adjustments* per visit effective for the final settlement year multiplied by the number of Medical Assistance outpatient visits for the period, or
3. The sum of the interim clinical diagnostic laboratory reimbursement
   plus the lesser of the following for other services (other than the above laboratory services):
   a. Total outpatient charges for other services in the final settlement year, or
   b. Total audited costs for other services in the final settlement year.

(As of July 1, 1996, the rural hospital adjustment will not be paid in addition to cost. State statute requires that payments, including rural hospital adjustment payments, be limited to cost.)

The cost of air, water and land ambulance service are not reimbursable costs for outpatient hospital providers.

4200 Calculation of Rate Per Outpatient Visit

A *rate per outpatient visit* will be established for each hospital for use as one of the payment maximums in the respective hospital's retrospective final settlement. The rate will apply to all covered outpatient services provided by the hospital during its final settlement year except for triage services paid under §5600 below. Calculation of the rate is described below and an example calculation is shown in the appendix.

The audited allowable cost attributed to outpatient services provided Medical Assistance recipients during the hospital's outpatient base year will be divided by the number of Medical Assistance recipient visits during the base year. The result is the base year cost per outpatient visit.

The following adjustments will be applied to the base year cost per outpatient visit to establish the *rate per outpatient visit*. More than one rate per outpatient visit may apply to a hospital's final settlement year depending on the effective dates of rate adjustments and the period of a hospital's settlement year.

TN # 96-022
Supercedes: TN # 94-022
Approval Date DEC 18 1996 *Effective Date 7/1/96*

1. *Increase for mental health services.* Outpatient base year allowable costs shall be adjusted to allow increased payment for outpatient mental health services. A hospital's outpatient base year allowable costs shall be increase by 2% of the Wisconsin Medical Assistance Program payments to the hospital for outpatient mental health services provided in calendar year 1990.

2. *Capital cost reduction.* Capital costs, which are included in the base year outpatient allowable costs, shall be reduced by 10% for all hospitals.

3. *Base year increase.* Base year costs, after including the above two adjustments, shall be increased by the appropriate percentage below.

For outpatient base years beginning on or between	Adjustment Factor Effective July 1, 1997	Effective July 1, 1998
January 1, 1987 through June 30, 1987	15.98%	18.30%
July 1, 1987 through January 1, 1988	13.70%	15.97%

4300 Calculation of Rural Hospital Adjustment Per Outpatient Visit

4320 Qualifying Criteria. A hospital may qualify for the rural hospital adjustment to its outpatient payment if it meets all of the following criteria:

1. The hospital is located in a rural Wisconsin area, which means that it is not located in a metropolitan statistical area (MSA) which is being used by HCFA in the Medicare program as of the effective date of the annual update.
2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
3. The hospital has not been permanently assigned MSA status by HCFA as of July 1, 1993.
4. The hospital is not classified as a Rural Referral Center by Medicare.
5. For annual updates on and after July 1, 1998, the hospital's combined Medicare and Medicaid utilization rate of the hospital, *as determined based on charges,* has been equal to or greater than 50.0%. For annual updates prior to July 1, 1998, the hospital's combined Medicare and Medicaid utilization rate of the hospital, *as determined based on charges,* has been equal to or greater than 55.0%.

The hospital's combined Medicare and Medicaid utilization rate will be determined based on charges for inpatient and outpatient services provided during the hospital's fiscal year which ended in the calendar year ending two years prior to the annual update. (Example, for July 1, 1995, the hospital's fiscal year ending in 1993 will be used). The hospital's total charges for Medicare (Title XVIII) and Medicaid (Title XIX) services will be divided by the hospital's total charges for all patient services provided during its fiscal year, resulting in the combined Medicare and Medicaid utilization rate. Hospitals that receive an adjustment under this section are not eligible to receive a critical access hospital interim cost payment adjustment under section 6890.

4330 Annual Update. A hospital's qualification for the rural adjustment will be annually determined for each July 1 and, if qualifies, will have its rural adjustment recalculated effective each July 1.

4340 Calculation of Payment. The amount of the rural hospital adjustment will be based on the hospital's Medicaid utilization rate for services provided during its fiscal year that ended in the calendar year ending two years prior to the annual update. (Example, for July 1, 1995, the hospital's fiscal year ending in 1993 will be used). The hospital's total charges for Medicaid covered inpatient and outpatient services will be divided by the hospital's total charges for all patient services provided during its fiscal year. Charges from out-of-state Medicaid programs may be included in the calculation if a hospital requests an administrative adjustment under section 6850.

The resulting Medicaid utilization rate shall be used to select the hospital's rural hospital adjustment percentage according to the following table. The adjustment percentage multiplied by the rate per outpatient visit determined according to section 4200 shall be the *rural hospital adjustment per outpatient visit*. The rate per outpatient visit used from section 4200 will not include any administrative adjustments for case mix, capital expenditures and combined settlement years.

(Adjustment percentages are listed on next page, page 4.)

Outpatient Rural Hospital Adjustment, Continued

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage Effective July 1, 1995	[Continued Effective 7/1/99]
Up through 7.5%	15%	
7.6% through 9.9%	23%	
10.0% through 12.5%	31%	
12.6% and greater	39%	

4360 Source of Charges Information for Calculating Utilization Rates. For calculating the utilization rates, total charges and Medicare (Title XVIII) charges will be based on the charge's reported by the hospital in its "Fiscal Year Hospital Fiscal Survey" for its fiscal year which ended in the calendar year ending two years prior to the annual update. (Example, for July 1, 1995, the hospital's fiscal year ending in 1993 will be used). Charges for Medicaid (Title XIX) services will be based on Medicaid claims submitted to the WMAP and will not include charges for services which were covered in full or part by Medicare and charges for services which the WMAP did not make a payment to the hospital (such as hospital stays for which insurance paid the full amount which the WMAP would have paid).

4800 If Audited Base Year Cost Report Is Not Available

Hospitals, for which the Department does not have an audited cost report available for the hospital's first fiscal year beginning on or after January 1, 1987, shall have claims paid at 83% of charges until after such time as an audited cost report is obtained by the Department for the hospital's first fiscal year beginning on or after January 1, 1987.

If the unavailability of an audited cost report for such an annual period is due to the hospital being newly certified or reinstated for participation in the Wisconsin Medical Assistance Program, an audited cost report covering at least six months of the outpatient base year shall be used. If such a six month audited cost report is or will not be available for such a hospital, then the audited cost report for the hospital's subsequent fiscal year shall be used. Upon receipt of the audited cost report, Medicaid allowable costs from the cost report will be deflated to 1987 dollars by applying the appropriate DRI/McGraw Hill, Inc. hospital market basket index.

The Department will calculate an average outpatient rate per visit according to the methodology described above. Payments made on a percentage-of-charges basis will be retroactively adjusted using the rate per visit. Claims will be paid at 83% of charges until such time as a cost report can be obtained for the hospital's first fiscal year after being certified.

4840 Payment Rates for Hospitals Combining Into One Operation

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For hospitals that combine into one operation under one WMAP provider certification on or after July 1, 1995, the rate per outpatient visit will be a combined average. The rate per outpatient visit for the combined or absorbing hospital will be a weighted average of the rates per outpatient visit, including the rural hospital adjustment, of each of the previous individual hospitals. The weighting for the average will be the number of WMAP recipient outpatient visits for each of the previous individual hospitals from at least a one year period which ended six months or more before the merger, consolidation or absorption.

Whenever the rural hospital adjustment is to be recalculated, the qualifying criteria, except criteria #2 and #3 of section 4320, shall be applied to the combined or absorbing hospital. Charge data of each of the previous individual hospital will be combined to calculate utilization rates if the required data for the specified time period is not available for the combined or absorbing hospital.

5000 REIMBURSEMENT FOR OUTPATIENT SERVICES PROVIDED OUT-OF-STATE

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, shall be paid at 50% of allowed charges. Reimbursement for diagnostic laboratory services will be the lower of laboratory fee schedule amounts of the Wisconsin Medical Assistance Program or the hospital's laboratory charges for services rendered. Payment for outpatient services provided by out-of-state hospitals which are not certified as border status will be limited to emergency services or services prior authorized by the Wisconsin Medical Assistance Program.

5500 BORDER METROPOLITAN STATISTICAL AREA (MSA) SUPPLEMENT

5520 Qualifying Criteria. A hospital may qualify for a border MSA supplement payment if it is located in a metropolitan statistical area (MSA) which has its primary urban area located in a state other than Wisconsin. MSA designations to be used are those used by HCFA in the Medicare program on July 1, 1993.

5530 Calculation of Payment. A monthly payment will be determined for each qualifying hospital based on the amount of outpatient services which were provided to Wisconsin Medical Assistance Program (WMAP) recipients. Total annual supplemental payments to all qualifying hospitals shall not exceed an annual target amount. A monthly payment amount will be determined according to the following formula effective May 1994 through June 1995. As of July 1995 and each July thereafter, the payment amount will be updated and effective for each 12 month period, July through June.

V	=	Number of WMAP outpatient visits in the 12 month period which begins in the month of July, two calendar years prior to the effective date of the MSA supplement update. (Example, for the May 1, 1994 effective date, the 12 month period will be July 1992 through June 1993; for a July 1, 1995 effective date, July 1993 through June 1994 will be used.)
W	=	Weighting factor from table in §5540 below
V x W	=	Weighted visits of a qualifying hospital
ΣV x W	=	Sum of weighted visits of all qualifying hospital
T	=	Statewide expenditure target amount as stated in §5560 below
M	=	Monthly payment to the qualifying hospital

Calculation: [(V x W) / (ΣV x W) x T] / 12 months = M

5540 Weighting Factor. The weighting factor (W) will be selected from the following table based on the hospital's Medicaid utilization rate for services provided during its fiscal year which ended in the calendar year ending two years prior to the effective date of the supplemental payment. (Example, for May 1, 1994, the hospital's fiscal year ending in 1992 will be used; for a July 1, 1995 effective date, the hospital's fiscal year ending in 1993 will be used.) The hospital's Medicaid utilization rate will be the hospital's total charges for WMAP covered inpatient and outpatient services divided by the hospital's total charges for all patient services provided during its fiscal year. Total charges will be based on the charges reported by the hospital in its "Fiscal Year Hospital Fiscal Survey". Charges for WMAP services will be based on Medicaid claims submitted to the WMAP and will not include charges for services which were covered in full or part by Medicare and charges for services for which the WMAP did not make a payment to the hospital (such as hospital stays for which insurance paid the full amount for which the WMAP would have paid).

Medicaid Utilization Rate	Weighting Factor
Up through 7.5%	15
7.6% through 9.9%	30
10.0% and greater	45

5560 Target Amount. The annual target amount will be $250,000.

5600 TRIAGE PAYMENT FEE FOR PRIMARY PROVIDER PROGRAM

The Department may pay an evergency room triage fee in lieu of a hospital's outpatient rate per visit when the primary care physician of a recipient instructs the hospital to not further treat the MA recipient. This only applies to instate and border status general acute care hospitals when they serve MA recipients who are enrolled in the Wisonsin Medical Assistance Program (WMAP) primary provider program. Triage services paid under this provision will not be subject to final cost settlement and will not be included in the cost settlement described in §4100. (Note: Triage payment effective 7/1/94.)

TN # 94-022
Supercedes: TN # 94-017
Approval Date 12-23-94
Effective Date 7/1/94

5700 HOSPITAL OUTPATIENT EXTENDED NURSING SERVICES

Hospital outpatient extended nursing services are nursing services and respiratory care provided by nurses, for part of a day, in a group setting, on the site of an acute care general hospital approved under Wis. Admin. Code HSS 124. The nursing services must be administered by or under the direct on-site supervision of a registered nurse. All medical care services must be prescribed by a physician.

Prior Authorization. Hospital outpatient extended nursing services must be prior authorized by the WMAP and, if not prior authorized, will not be reimbursed. Only persons who require eight or more hours per day of nursing services as determined by the WMAP may qualify for outpatient extended nursing services. The request for prior authorization must describe the expected means by which the participant will regularly be transported between the participant's residence and the hospital.

Reimbursement. The reimbursement for outpatient extended nursing services shall cover all nursing services provided by the hospital. The services will be reimbursed at an hourly rate. The hourly outpatient extended nursing services rate may be billed only for the time during which an outpatient extended nursing services patient is physically present at the hospital and attended by a nurse or a hospital staff person under the direct supervision of a nurse. Any portion of a quarter of an hour of presence at the hospital for outpatient extended nursing services can be charged as a full quarter of an hour.

Effective April 1, 1995, the hourly payment rate for outpatient extended nursing services is $30.00 per hour per patient.

No Final Settlement. The reimbursement for outpatient extended nursing services will not be included in the outpatient final settlement described in section 4000.

Cost Reporting. A hospital must separately identify and report in its Title XIX cost report those direct and indirect costs attributable to the outpatient extended nursing services.

NEXT PAGE IS PAGE 5

TN # ~~95-004~~
Supersedes: Approval Date _____ 6/27/95 Effective Date 4/1/95
TN # New Page, Insert after page 4.1

Substitute page submitted 6-27-95

5800 SUPPLEMENTAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH)

Supplemental payments may be provided for any hospital located in Wisconsin which meets the criteria for an "essential access city hospital" (an EACH).

5810 Qualifying Criteria.

An EACH is an acute care general hospital with medical and surgical, neonatal ICU, emergency and obstetrical services available to WMAP inpatient recipients and is located in the inner city of a city of the first class in Wisconsin. An EACH must have 30% or more of its total inpatient days attributable to Medicaid patients including HMO Medicaid patients and must have 30% or more of its gross charge revenues attributable to inpatient and outpatient services which were provided to Medicaid patients, including HMO Medicaid patients, and to charity care.

An "inner city area" will be identified by contiguous U.S. Postal Service Zip Codes for the respective area. Once a hospital is designated an EACH, it may be eligible annually, using the State's fiscal year.

An EACH is expected to be committed to maintaining its effort to serve MA recipients including recipients in the inner city area. If during any rate year a hospital ceases to qualify as an EACH, then the Department will remove the EACH status effective with the date any of the criteria above are found to not have been met by the hospital. The Department may withhold or may retroactively recover EACH supplemental payments in proportion to the extent that the EACH does not meet its commitment to provide inpatient and outpatient services to MA recipients including MA HMO enrollees.

5820 Payment.

The EACH supplement shall be paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The total amount paid in a year July 1 through the subsequent June 30th cannot exceed the amount of the statewide EACH payment maximum which is allocated to the individual EACH.

The statewide maximum EACH payments will be allocated to an individual EACH according to the following formula where:

- v = Total MA outpatient visits, excluding HMO outpatient visits, for an individual EACH facility from the calendar year prior to July 1.
- V = Total MA outpatient visits, excluding HMO outpatient visits, for all EACH facilities in the state from the calendar year prior to July 1.
- A = Maximum on total annual statewide EACH payments for the July 1 through June 30 payment year.
- E = The portion of the statewide EACH maximum allocated to the individual EACH facility for the July 1 through June 30 payment year.

Formula: $(v \div V) \times A = E$

For the individual EACH, the portion of the statewide EACH maximum allocated to the hospital (E above) for the rate year will be divided by 12 to establish the monthly outpatient EACH payment for the hospital.

5830 Qualifying Inner City Areas.

As of July 1, 1997 one inner city area is covered which is represented by the following group of contiguous zip codes: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216, and 53233.

5840 Statewide Maximum.

The total statewide annual maximum on outpatient EACH supplemental payments is $300,000.

5850 MEDICAID UTILIZATION SUPPLEMENTAL PAYMENT

Utilization supplemental payments are provided to acute care hospitals located in Wisconsin that have provided a significant amount of services to Wisconsin Medicaid recipients in proportion to the total amount of inpatient and outpatient services provided by a hospital in the most recent fiscal year.

5860 Qualifying Criteria.

A hospital qualifies for a utilization supplement if it meets the following criteria:

(1) The hospital is an acute care hospital located in Wisconsin that provides services to Wisconsin Medicaid recipients;
(2) For the most recent fiscal year, the hospital's Wisconsin Medicaid inpatient and outpatient revenues equal at least 8% of the hospital's total inpatient and outpatient revenues.

5870 Determination of Medicaid Utilization Supplemental Payment.

The Medicaid utilization supplemental payment will be calculated for each qualifying hospital, as formulated below.

The statewide maximum utilization supplemental payments will be allocated to an individual qualifying hospital according to the following formula where:

r = Total Wisconsin Medicaid revenue for each qualifying hospital in the most recent fiscal year.
R = Total Wisconsin Medicaid revenue for all qualifying hospitals in the most recent fiscal year.
A = Maximum total statewide utilization supplemental payments for the July 1, 2000 through June 30, 2001 payment year.
P = The portion of the statewide utilization supplemental payment maximum amount allocated to a qualifying hospital based on each qualifying hospital's proportion of the total Wisconsin Medicaid revenue for most recent fiscal year.

Formula: (r/R) X A = P

The Medicaid utilization supplement shall be paid in a prospectively established monthly amount based on past Wisconsin Medicaid managed care revenue reported by the hospital and fee-for-service paid claims revenue data from the most recent fiscal year. Each qualifying hospital's annual hospital utilization supplemental payment, divided by twelve, will be the amount which will be paid to the hospital for each month of the year beginning July 1, 2000 through June 30, 2001.

5875 Source of Charges Information for Calculating Utilization

Wisconsin Medicaid utilization will be based on Wisconsin Medicaid fee-for-service inpatient and outpatient paid claims revenue data and Wisconsin Medicaid managed care inpatient and outpatient revenue reported by the hospital in the "Hospital Fiscal Survey" for the most recent fiscal year. The Department may request, at its discretion, additional audited data from a hospital to verify the information reported in the "Hospital Fiscal Survey". The Department may use the additional audited data to determine if the hospital qualifies for the hospital utilization supplement and to calculate the amount of the payment.

5880 Statewide Maximum.

The total statewide maximum for hospital utilization supplemental payments is $2,448,730 and is payable only in the rate year July 1, 2000 through June 30, 2001.

5900 OUTPATIENT INDIGENT CARE ALLOWANCE

Supplement Medicaid payments are provided to hospitals that provide a significant quantity of services to low-income persons covered by a county administered general assistance (GA) program and to Wisconsin Medicaid recipients. This supplement is the outpatient indigent care allowance. The identifying of services a hospital provides to persons covered by a county general assistance program is a reliable method for identifying the quantity of services a hospital provides low-income persons other than Medicaid recipients. Persons may be eligible for county administered general assistance under financial income criteria similar to or more restrictive than those for the Wisconsin Medicaid Program.

8210 Qualifying Criteria.

For a hospital to qualify for an outpatient indigent care allowance,

(1) at least 15% of the hospital's operating expenses must be attributable to inpatient and outpatient services provided persons eligible under the Wisconsin Medicaid Program and to low-income persons covered by a general assistance program administered by a county as determined under §8215,

(2) at least 5% of the hospital's operating expenses must be attributable to inpatient and outpatient services provided persons covered by a general assistance program administered by a county as determined under §8215, and

(3) a hospital that is not owned and operated by a county government must have a contract with a county government to provide medical services to low-income persons covered by the county's general assistance program, and

8215 Calculation of Qualifying Percentage for Specific Hospital

The percent of operating expenses attributable to services provided to the low-income persons is determined as follows. Section 8260 discusses the historical financial data to be used for a hospital which has combined with the operation of another hospital.

MAFFSIN MAFFSOUT	Total fee-for-service charges by the hospital to the Wisconsin Medicaid Program (WMP) for inpatient and outpatient provided services WMP recipients in the calendar year prior to the July 1 rate year. For example, for rate year beginning July 1, 1997, the calendar year of 1996 is used.
MAHMOIN MAHMOOUT	For inpatient and outpatient services provided WMP recipients covered by Medicaid HMO or managed care contractors, total charges by the hospital in the hospital's fiscal year that ended in the calendar year prior to the July 1 rate year. If charges not available, zero will be used. For example, for rate year beginning July 1, 1997, the hospital's fiscal year that ended in 1996 would be used.
GAIN GAOUT	Total charges by the hospital for inpatient and outpatient services provided persons covered by a county administered general assistance program (GA) in the calendar year prior to the July 1 rate year. For example, for rate year beginning July 1, 1997, the calendar year of 1996 is used.
RCC	The ratio of the hospital's overall costs to overall charges for hospital patient services, not to exceed 1.00, as determined from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
TOTEXP	Total hospital patient care expenses from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
MAEXPIN MAEXPOUT	Total expenses attributed to inpatient and outpatient hospital services provided to WMP recipients calculated as: *MAEXPIN = (MAFFSIN + MAHMOIN) x RCC And MAEXPOUT = (MAFFSOUT + MAHMOOUT) x RCC*
GAEXPIN GAEXPOUT	Total expenses attributed to inpatient and outpatient hospital services provided persons covered by a GA program adminstered by a county calculated as: *GAEXPIN = GAIN x RCC And GAEXPOUT = GAOUT x RCC*
GAPERC	Percent of hospital's operating expenses attributable to services provided persons covered by a GA program adminstered by a county calculated as: *GAPERC = (GAEXPIN + GAEXPOUT) / TOTEXP*
TOTPERC	Percent of hospital's operating expenses attributable to services provided persons covered by (a) a GA program administered by a county and (b) the Wisconsin Medicaid Program (WMP) calculated as: *TOTPERC = (GAEXPIN + GAEXPOUT + MAEXPIN + MAEXPOUT) / TOTEXP*

Not to be included in charges are those charges made by the hospital to county administered programs required by state statute for the prevention or amelioration of mental disabilities and for the provision of services to developmental disabled persons and their families. (i.e., programs required or authorized under Wis Stats, §51.42 and §51.437.)

5100 Critical Access Hospitals

Definition: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by HCFA, and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

Interim Payment Rate Per Visit: A critical access hospital will be reimbursed at the interim rate described in section 2100. The interim rate may be increased by an interim amount determined under the administrative adjustment, Section 6890, "Critical Access Hospital Interim Cost Payment Adjustment."

Final Settlement: A critical access hospital will be reimbursed according to the final settlement provisions under section 4000. The rate per visit limitation of section 4000 will not include any "Critical Access Hospital Interim Cost Payment Adjustment." The critical access hospital will be reimbursed any additional reimbursement that results from the following calculations.

Calculation of Reimbursable Critical Access Hospital Cost: The reimbursable critical access hospital cost of providing outpatient hospital services for Medicaid recipients will be determined. Reimbursable critical access hospital cost will be the lesser of:

1. Customary outpatient charges in the final settlement year,
2. The sum of the interim clinical diagnostic laboratory reimbursement plus the lesser of the following for the other services (other than the above laboratory services);
   a. Total outpatient charges for other services in the final settlement year, or
   b. Total audited costs for other services in the final settlement year.

Reimbursable critical access hospital costs will be compared to the total final settlement amount of section 4000.

Limits on Final Settlement:

If the final settlement under section 4000 results in an amount due to the WMAP, this amount may be applied to any amount owed to the hospital under the critical access hospital inpatient reimbursement provisions.

If the reimbursable critical access hospital costs exceed the section 4000 total final settlement amount, the Department will reimburse the hospital the amount by which costs exceed payments after such amount is reduced by the amount, if any, by which payments exceed costs under section 5900 of the Inpatient Hospital Plan relating to critical access hospital inpatient reimbursement.